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FEMALE GENITAL MUTILATION

A Review of Current Literature

Ian Ferguson
Pamela Ellis

WD1995-15e

UNEDITED

Research, Statistics and Evaluation Directorate/
Direction générale de la recherche,
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EXECUTIVE SUMMARY

Female genital mutilation is recognized by many as an issue of medical, social and legal concern. While the term "female genital mutilation" (FGM) has only recently been coined, the practice has a long and complex history. At present, female genital mutilation remains common in many cultures in Africa and the Middle East, varying in form and severity as a result of each group's socio-cultural norms and belief systems. It is estimated that approximately 100 million girls and women alive today are affected by female genital mutilation.

Female genital mutilation can have severe medical and psychological consequences for the girls and women on whom it is performed. Government, international human rights bodies, and non-governmental organizations have engaged in efforts to eradicate the practice of FGM, including specific legislation prohibiting the practice, public education campaigns and international conventions and resolutions condemning the practice.

The findings of this report show that the majority of the literature on female genital mutilation condemns the practice as a result of the medical, legal, human rights, historical, and religious arguments against it. This literature review examines these issues with particular reference to positions held by international organizations such as the UN and the WHO, as well as those advanced by feminist, medical, governmental and non-governmental organizations throughout the world. In addition, relevant concepts and definitions were presented both to eliminate misconceptions surrounding FGM, and for use in future works addressing this issue.

The majority of the research reviewed here adopts the predominantly Western perspective that female genital mutilation is a violation of human rights, and the literature stresses the numerous short and long-term physical and psychological consequences that result from the procedure. In the literature, the practice of FGM is examined in the context of (1) male domination over women and children, (2) religious misinterpretation (primarily of the Qu'ran), and (3) a lack of medical justification for the procedure.

Fewer studies focus on the pressures faced by members of many immigrant populations who continue to view FGM as a positive and acceptable practice. A lack of understanding of the views of these cultures may impede the effectiveness of organizations attempting to implement viable proposals for change. Moreover, there is a lack of literature offering comprehensive examinations of the diverse nature of the societies where FGM is still performed.

This literature review examines the issue of female genital mutilation from many different perspectives. Such a comprehensive examination of the literature allows for a re-thinking of ways to approach FGM at the levels of education, legislation, and other preventative action in order to eliminate public misconceptions (both inside and outside of affected cultures) of practice.

1.0 INTRODUCTION

1.1 Purpose

Female genital mutilation is recognized by many as an issue of medical, social and legal concern. While the term "female genital mutilation" (FGM) has only recently been established, the practice has a long and complex history. It is known that in ancient Egypt FGM was a symbol of status and prestige among the aristocracy, and the custom has been documented in other countries including pre-Islamic Arabia, ancient Rome, Tsarist Russia, the United States and Europe (Hedley & Dorkenoo, 1992: 5).

Female genital mutilation is common in many cultures in Africa and the Middle East, varying in form and severity as a result of each group's socio-cultural norms and belief systems. It is estimated that between 85 and 115 million girls and women alive today have undergone female genital mutilation (WHO, 1994). A review of the literature indicates that the number appears to be increasing.

This report is intended to be a general resource on female genital mutilation. Included is an overview of the literature with particular reference to issues arising from the practice of FGM in Canada, the United States, Britain, Western Europe, Australia, and New Zealand; and a discussion of current research on FGM, legislation that applies to its practice, medical and psychological concerns, and national and international attitudes towards FGM. Further, a series of definitions that may be used to discuss the problem of FGM in future works are set out in chapter 2.0.

1.2 Organization

This paper consists of 6 chapters and a bibliography of the literature.

- Chapter 1.0 outlines the organization of the report, sets out its purpose and identifies the data sources used to gather information for this literature review.
- Chapter 2.0 describes the various forms of female genital mutilation, its physiological and psychological consequences, and its present geographical distribution.
- Chapter 3.0 examines the tension between universal human rights and cultural self-determination as they relate to female genital mutilation.
- Chapter 4.0 focuses on actions taken by some Western and African nations to prohibit the practice of FGM.
- Chapter 5.0 discusses how the practice of FGM has been treated in Canada.

- Chapter 6.0 summarizes the main points that can be taken from the literature review.

1.3 Data Sources

The literature cited in this report was compiled through a computerized search of a number of databases. The Carleton University Bibliographic Enquiry (CUBE) main and current contents databases, the Ottawa Recherche Bibliographique/ Bibliographic Information System (ORBIS), Psychlit, and Sociofile were all searched in June 1995. The Minority Advocacy Rights Council (MARC) database, which deals with justice issues of concern to ethnocultural groups, was searched in May 1994. Two requests were also made on the Access to Justice Network (ACJ-Net). No responses were received with respect to the first request, which was made in May 1994. The second request, made in July 1994, received 12 responses, which are discussed in this paper. Lastly, a search for relevant articles, discussion groups, and photo/video data was carried out using key-word identifiers on the Internet World Wide Web (WWW), Gopher, and Use-Net newsgroups in June 1995. The key words were: 'female genital mutilation', 'FGM', 'female circumcision', 'circumcision', 'excision', 'Sunna', 'introcision', and 'infibulation'.

Manual searches were made at the Ottawa Public Library, the Department of Justice main library, the Carleton University Women's Center, as well as the "Anthropology Abstracts", "Sociology Abstracts", and "Women's Studies Abstracts". In addition, newspaper scans were conducted from March 1994 to May 1995. This did not involve an exhaustive scan of every newspaper, rather, some newspapers were scanned to monitor the amount of media coverage dedicated to FGM.

Finally, the following institutions were contacted: the Carleton University Women's Center, the Carleton University International Student Center, Women's Health in Women's Hands, the Ontario Woman's Directorate, Foreign Affairs and International Trade, Canadian International Development Agency, Family Services Canada, Public Affairs Information Service: Human Rights and Justice, Women's International Network News, United Nations International Women's Equity, the British High Commission, the Australian High Commission, the New Zealand High Commission, the Royal Canadian Mounted Police (RCMP), the Federal Bureau of Investigation's National Center for the Analysis of Violent Crime, the FBI Behavioral Science Unit, the Academy Group Inc., the People's Law School of British Columbia, the National Film Board of Canada, the College of Physicians and Surgeons of Ontario, and the World Health Organization.

2.0 THE CONSEQUENCES OF FEMALE GENITAL MUTILATION

This chapter describes the different forms of female genital mutilation, the current geographic distribution of the practice, physical and psychological consequences, and justifications for the continued practice of FGM.

2.1 Definitions

The term "female genital mutilation" (FGM) applies to any procedure involving the removal of all or part of the vulva and/or the clitoris. Although FGM is commonly referred to as "female circumcision"[1], four different procedures are actually subsumed in the broader general term "female genital mutilation", namely: Sunna or clitoridectomy, excision, infibulation or Pharaonic 'circumcision', and introcision[2]. Although not discussed in this literature review, certain forms of genital scarification and piercing customs may also be considered female genital mutilation (Vale & Juno, 1989).

2.1.1 Sunna Circumcision or Clitoridectomy

From the Arabic term for "tradition", Sunna circumcision remains a rite of passage in both the Islamic and Moslem religions (Bardach, 1993: 125). This procedure involves the removal of the clitoral prepuce or hood, while the clitoris itself is left intact. It has been suggested that Sunna is the only form of female genital mutilation that is 'comparable' to male circumcision (Hedley & Dorkenoo, 1992: 5).

2.1.2 Excision

The most frequent type of genital mutilation that occurs throughout Africa involves the removal of the entire clitoris, usually together with the labia minora, and in some instances, the labia majora (Sanderson, 1981: 4).

2.1.3 Infibulation or Pharaonic Circumcision

The main objective of infibulation is to render pre-marital sexual intercourse impossible. Excision with infibulation consists of the removal of the entire clitoris, labia minora, and labia majora, with the sides of the wound being sewn together. Immediately following this procedure, the girl's legs are usually braced to keep her immobilized for a period of up to 40 days as the vulva heals. During this healing

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[1] The word 'circumcision' will not generally be used in this paper to mean FGM. FGM does not compare medically to a male circumcision involving the removal of the foreskin from around the glans of the penis.

[2] It is important to note that these terms may be used in different contexts by different authors (i.e., the terms excision and clitoridectomy have been used interchangeably in the literature that was researched for this report).

process, a tiny hole is created in the wound by inserting a small object (for example, a piece of wood or bamboo) in it to allow for the passage of menstrual blood and urine (Hedley & Dorkenoo, 1992: 1). At the time of sexual intercourse or childbirth, the scar tissue needs to be cut open. After childbirth, women are often re-infibulated.

2.1.4 Introcision

This is the least frequently performed and documented type of FGM. Introcision involves the cutting into the vagina and/or splitting the perineum in order to widen the vaginal opening (Sanderson, 1981: 4). At present, there is no literature indicating the prevalence or geographic distribution of this procedure.

2.2 Geographic Distribution of the Practice of FGM

The practice of female genital mutilation occurs throughout the world. The International Planned Parenthood Federation estimates that between 85 and 115 million girls and women living today in the Arab world, sub-Saharan Africa, Malaysia, Indonesia, as well as in immigrant populations in Canada, the United States, Europe, Australia and New Zealand, have undergone this traditional procedure (duRocher, 1992: 11). Furthermore, the World Health Organization (WHO) estimates that up to 2 million girls are at risk of female genital mutilation annually (World Health Organization, 1994).

Currently, only anecdotal accounts outline the range and forms of female genital mutilation allegedly practised in North America, Europe, Australia and New Zealand. Data does exist, however, for the regions where FGM remains a traditional custom. Sunna circumcision continues in North and South Yemen, Saudi Arabia, Iraq, Jordan, Syria, and Southern Algeria. Cases of excision are found throughout Africa, including Egypt, Mozambique, Botswana, and Lesotho. Infibulation remains customary in Somalia, Ethiopia, the Sudan, Kenya, Nigeria, Mali, Burkina Faso (previously Upper Volta), and parts of the Ivory Coast. Although little information is available, it has been documented that this procedure is practised by Muslim populations in the Philippines, Malaysia, Pakistan, Indonesia, Brazil, Mexico, and Peru (Table 1) (duRocher, 1992: 11).

Table 1 Geographic distribution and prevalence of FGM

COUNTRY	% PREVALENCE OF FGM (all forms)
Somalia	close to 100 %
Djibuti	close to 100 %
Ethiopia	90 %
Mali	90 %
Sudan (North)	90 %

Sierra Leone	90 %
Burkina Faso	70 %
Gambia	60 %
Ivory Coast	60 %
Kenya	60 %
Senegal	50 %
Egypt	50 %
Guinea	50 %
Guinea Bissau	50 %
Nigeria	50 %
Mauritania	25 %
Central African Republic	20 %
Niger	20 %
Chad	20 %
Benin	20 %
Togo	20 %
Ghana	20 %
Tanzania	10 %
Uganda	under 5 %
Zaire	under 5 %
Sub-Saharan Africa	N.A.
North America	N.A.
Central America	N.A.
South America	N.A.
United Kingdom & Europe	N.A.
Asia	N.A.
Australia & New Zealand	N.A.
Other	N.A.

The figures relating to female genital mutilation and its geographic distribution came from *Female Genital Mutilation: Proposals for Change* (Minority Rights Group, 1992: 22).

2.3 Physical Consequences of FGM

Medical reports document many immediate and long term physical consequences of FGM. The form and severity of these effects depends on several factors: the age of the girl on whom FGM is performed; the conditions in which the procedure is performed; the overall health of the girl; and the skill of the person performing the procedure.

2.3.1 Immediate Physical Consequences

Safe removal of only the prepuce of the clitoris demands that the individual performing the procedure have advanced medical and anatomical knowledge, good quality surgical tools, and that the girl on whom the procedure is to performed be motionless and anesthetized. These factors are almost always absent when Sunna is performed in African and Middle Eastern cultures (Bardach, 1993: 125). Sudden movement by the girl can result in damage to adjacent organs, cutting of an artery or

shock which would harm or even prove fatal to the girl or woman[3] (Dorkenoo & Hedley, 1992: 22).

As the clitoris is rich in blood vessels, hemorrhaging may occur as a result of complete removal of the prepuce and clitoris. Infection may also be a consequence of FGM. Tetanus and septicemia may ensue from the use of unsterilized tools and from unsanitary working conditions (Brown, Calder, & Rae, 1989). The risk of HIV transmission is also increased due to the use of the same unsterilized tools on several girls (Bongers, 1994: B8).

2.3.2 Long-Term Physical Effects

Once the lacerations resulting from FGM have healed, a scar forms. The scar tissue narrows the genital opening making it difficult to pass urine and menstrual blood[4]. Due to the decrease in size of the vaginal opening, menstrual blood may be retained in the body, resulting in bloating and swelling of the abdomen (Armstrong, 1991: 43).

Due to the inelasticity of scar tissue, sexual intercourse and childbirth can also become complicated and painful. An infibulated woman's husband will sometimes use unsterilized tools such as a knife or scissors to enlarge the vaginal opening in order to facilitate intercourse. The resulting open wound leaves the woman at greater risk of HIV transmission by her husband as well as infection with other agents from the unsterile tools (Hosken, 1982). Similarly, an anterior episiotomy (de-infibulation) may be required during childbirth to decrease the risk of fetal asphyxia and hemorrhaging by the woman during the birthing process (Arbesman, Kahler, Buck, 1993; Baker, Gilson, Vill, Curet, 1993: 1617).

2.4 Psychological Side Effects of FGM

Although little research has been conducted regarding the psychological impact of FGM, there is some anecdotal evidence that psychological trauma occurs as a result of FGM. For example, Alice Muir-Leach describes the changes in behavior that she observed among young Sudanese girls as a result of genital mutilation:

> Before the ordeal, the infibulation, they were friendly, clear eyed normal children, and had no fear of a medical examination. But a child who had been recently infibulated, when seen some two months later or even up to two years later, showed a very different picture. She stood trembling with fear at the open door,

[3] For example, in May 1995, a rural Egyptian barber was arrested for performing FGM on two young girls using a razor blade. The first girl (age 10) died as a result of massive blood loss and an over-dose of painkillers, while the second girl (age 12) was admitted to hospital in serious condition with heavy bleeding (Guzda, 1995).

[4] It has been documented that the average time required by an infibulated female to urinate is 10 to 15 minutes (Slack, 1988: 452).

> or else bolted into the examination room and crouched in the far corner, and it was with difficulty that she was persuaded to remove even her outer garments. Others with more courage, approached trembling and stood weeping silently. They were terrified at the sight of a metal instrument such as a stethoscope or spatula. In all cases the sound of a metal spatula being lifted from the tray caused a slight trembling even if the examination had proceeded normally till then. In others, the sight of the spatula in my hand brought on a nerve storm, and it was impossible to continue. This seems to indicate an unreasoning fear of surgical instruments (Passmore Sanderson, 1981: 42).

One might expect there to be profound psychological effects as a result of this practice since it is "...well known that extensive and enduring pain can create deep psychological wounds" (Slack, 1988: 454) that cultural pressure to conform may mitigate psychological suffering. For example, if a community stresses that a girl's clitoris or genitals are 'dirty', or that she is in some way living outside of the community's established 'norms', she may feel psychologically relieved to be 'made' like everyone else. Alice Walker, in her novel, *Possessing the Secret of Joy* illustrates this pressure to conform:

> To all my friends who'd been circumcised, my uncircumcised vagina was thought of as a monstrosity. They laughed at me. Jeered at me for having a tail. I think they meant my labia majora. After all, none of them had vaginal lips; none of them had a clitoris; they had no idea what these things looked like; to them I was bound to look odd. There were a few other girls who had not been circumcised. The girls who had been would sometimes actually run from us, as if we were demons. Laughing, though. Always laughing (1992: 121).

3.0 FEMALE GENITAL MUTILATION: THE CULTURAL PRACTICE AS IT RELATES TO HUMAN RIGHTS

It has been argued that FGM is a ritual involving body modification which serves to mark a girl's transition from one stage of life to another (Roberge, 1983). However, others have argued that FGM can cause severe physical consequences and may have an impact as well on the girls and women who are subjected to them. Moreover, such customs are currently perceived by many as acts of subjugation of women and children (Sanderson, 1981).

3.1 FGM and Cultural Identity

If FGM rituals were performed on a purely symbolic level without any resultant medical/psychological effects on girls and women, then it may not be viewed as an issue of concern. However, as detailed in chapter 2.0, female genital mutilation is still being practised in its original forms by many cultures around the world. According to Hibani (1994), many immigrant communities still regard FGM as a valuable custom in their country of origin; some of which have a 99 percent 'circumcision' rate among young girls.

Girls undergo FGM as a rite of passage: a social transition from one individual and/or community status level to another in order to obtain communal recognition[5] (Harris, 1987: 269; Lowenstein, 1978: 417). Each cultural group that practices FGM develops its own socio-cultural 'justifications' for its actions, which support the construction of the rite of passage.

Although it has been documented that FGM is practised by Muslim, Catholic, Protestant, Animist, atheist, and agnostic communities, a common justification for the practice is that it is a required Islamic custom (Dorkenoo & Elworthy, 1992: 13). Further examples of cross-cultural religious and cultural justifications for FGM have been collected and documented by Dr. Omer Hashi:

- To ensure chastity before marriage
- To facilitate the marriage of young women
- To decrease the risk of nymphomania
- To reduce female sexuality and prevent masturbation
- To improve and facilitate cleanliness
- To increase fertility
- To keep the genital region smooth for aesthetic reasons

[5] As mentioned in section 2.1, male circumcision and what some have labelled 'female circumcision' do not compare medically. Yet on a symbolic level, they are comparable in that male circumcision is also practiced as a rite of passage in numerous cultures worldwide. For example, adolescent Ndembu boys are required to partake in elaborate rituals in which they are removed from their community, circumcised, and subject to beatings and profound disciplinary action in order to pass on to manhood (see Victor Turner's ethnography *The Forest of Symbols. Aspects of Ndembu Ritual* (1967: 205-216)).

- To remove obstruction to sexual intercourse caused by a very large labia
- To tighten the vagina to increase sexual pleasure for men
- To be accepted as a full member in social groups, tribes, religious orders, etc.
- To fulfill religious requirements
- To confer the right for women to speak at public meetings
- To enter a mosque in some communities
- To attain the right to inherit property
- To avoid disgracing the family (Omer Hashi, 1993(b): 538).

Some have questioned the rationale for such 'justifications'. As an example, the practice of FGM as an initiation into adulthood has been questioned as the age of mutilation becomes younger (Minority Rights Group, 1985). These justifications have, nonetheless, become deeply ingrained within the cultural fabric of traditional practising communities. Because many of these practices are believed to have existed for centuries, recent changes in attitudes concerning FGM, along with attempts to change or eliminate it, have proven difficult. The literature suggests that among feminist, medical, governmental and non-governmental groups, the current trend is toward eradicating the practice of FGM by increasing understanding of the issue through public education. As a result, the health risks associated with such practices have been emphasized, religious myths surrounding FGM have been dispelled, and the legal repercussions of practising FGM have been outlined where appropriate (Hedley & Dorkenoo, 1992; Hussein & Shermarke, 1995).

Due to the fact that most forms of female genital mutilation involve the mutilation or removal of the clitoris, several quasi-medical 'justifications' for this action have also been noted. For example, some members of Somali and Sudanese communities believe that the clitoris is a dangerous organ that, if not removed, will continue to grow, and that a girl with a clitoris will engage in acts of delinquency and/or prostitution. Others believe that an intact clitoris will cause death to a newborn child if the clitoris comes in contact with the infant's head during childbirth (Hedley & Dorkenoo, 1992: 6; Jones, 1992: 11).

Examples exist of younger generations of immigrant females embracing FGM because it is a tradition. It has been documented that many immigrant teenage girls are appalled at the notion that FGM is looked down upon, both inside and outside of their culture. Furthermore, feelings of resentment towards uncircumcised girls in general may continue to exist. As stated by an anonymous source in the documentary "Our Daughters' Pain: Female Genital Mutilation" (1995):

> When I came to Canada, I see that a lot of teenage girls my age have babies. I feel sick when I see those girls. They don't have a father, the babies, y'know. Why? Because, I mean I know some girls like that, but circumcision makes me protected. It makes me a lot of things.

This suggests that the continued practice of FGM has arguably been maintained through the process of enculturation[6], establishing it as an integral element in the religious and traditional lifeways of these cultures. When introduced into Western society, the enculturated values of immigrant women may conflict with the lifeways of the general public. As a result, law enforcement, social work, and health care professionals will encounter problems when confronted with cases of FGM -- a result of a lack of understanding of FGM, the socio-cultural group(s) in question, and in more severe cases, Western ethnocentric ideologies.

3.2 FGM as a Violation of Human Rights

As stated above, some have argued that FGM is a cultural tradition within various societies (Roberge, 1983; Barron, 1991). Although there have been many justifications advanced for the continued practice of FGM, it appears that such views are not widely accepted as there are (perhaps more convincing) reasons to eradicate it.

The literature suggests that opposition to the practice of female genital mutilation is based on a series of interconnected issues, each related to universal human rights. Hedley & Dorkenoo (1992-93) suggest that FGM can be viewed as a violation of human rights from a variety of different perspectives. For example, (1) FGM is in no way medically justifiable and infringes on an individual's right to good health; (2) FGM violates the rights of children; and (3) FGM can be seen as both an act of violence against women/girls and of male domination over women/girls.

Because attitudes concerning FGM differ significantly between affected and non-affected cultures, it has been difficult to change or eradicate these traditional practices at the international level. Evidence suggests that in order to be supported by the international community, any proposals for change in or eradication of the practice put forth by international organizations (i.e., the United Nations or the World Health Organization) must be done with respect to national and international human rights laws. Examples in the literature include:

1. Decisions (made by both affected and non-affected cultures) regarding the modification or eradication of the practice of FGM must be made with regard to the advancement of universal human rights (Harvard Law Review, 1993: 18).

2. A women's right to be free from oppressive traditional socio-cultural practices if she deems it necessary must be upheld and protected.

3. Means for protecting a cultural group's right to practise traditional customs must be proposed so that the group may continue practising them without interference from the state (Cerny Smith, 1992: 2489).

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[6] Enculturation, as defined by Harris, is a "...learning experience whereby the older generation invites, induces, and compels the younger generation to adopt traditional ways of thinking and behaving" (Harris, 1987: 7).

4. An international consensus over what behavior is considered 'acceptable' with regard to human rights norms must be reached before any such decisions can be acted upon (Brennan, 1989: 395).

4.0 INTERNATIONAL TREATMENT OF FEMALE GENITAL MUTILATION

4.1 The United Nations

The United Nations is a general international organization established to promote international peace and security, to debate major world issues, and to help improve low standards of living and economic conditions throughout the world.

During the International Year of the Child (IYC), the United Nations published a series of newsletters from its secretariat in New York. The April 1978 issue included an article entitled "Female Circumcision as a Health Hazard". The article stated:

> ...there are many areas in which advocacy on behalf of children needs to be stimulated. One of the lesser-known -- or perhaps even unknown -- areas is that of female circumcision in its several forms, which is traditionally practiced on young girls in some 26 countries. Besides the psychological aspects, the effects of genital excision, except in its mildest form, result in severe health hazards both at the time of the operation when the girl is young and later on during a woman's child-bearing years. Infection, urinary retention, damage to the urethra, keloid formation and cysts, are only a few of the documented dangers. Infertility can also result (in Hosken, 1982).

This was one of the first official statements to appear from an international organization that cautioned against the practice of FGM.

Since that time, a number of sub-organizations of the UN have addressed the issue of female genital mutilation as a violation of human rights. The most important statements on FGM made by UN-related bodies follow in chronological order.

4.1.1 1979 World Health Organization (WHO) Seminar, Khartoum, Sudan

The World Health Organization is dedicated to researching, contributing information and providing technical assistance concerning health issues, setting international health standards, and aiding victims of natural disasters (Grolier Multimedia Encyclopedia, 1993).

In February 1979 in Khartoum, Sudan the World Health Organization held a seminar entitled "Traditional Practices Affecting the Health of Women and Children",

in which the main subject was female genital mutilation. This was the first time that FGM was discussed from the health point of view at an international gathering.

This seminar resulted in four unanimously supported recommendations: (1) the adoption of clear national policies for the abolishment of female circumcision; (2) the establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting FGM; (3) intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of FGM; and (4) intensification of education programs for traditional birth attendants, midwives, healers, and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice (Hosken, 1982: 43).

Hosken suggests that despite these recommendations, WHO personnel claim they have to take a passive stand, waiting for instructions from governments. She argues that decision-makers are seldom informed by WHO officers about the health risks FGM poses to a large segment of the female population, and that FGM should be classified as a public health hazard of major proportion in terms of the numbers of people affected, and the damage sustained (Hosken, 1982: 272).

4.1.2 1979 Convention on the Elimination of All Forms of Discrimination Against Women

CEDAW was organized to discuss methods of narrowing the gaps between the genders, with particular emphasis placed on education and employment, political and public life, marriage and family law, economic and social benefits, and legal equality. Resulting from this consultation are two articles that discuss the illegality of FGM.

Article 2 of the convention states:

> States parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women in all its forms, and to this end, undertake...
>
> (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

Article 5(a) states:

> States Parties shall take all appropriate measures:

(a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customs and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women (Oosterveld, 1993: 286).

4.1.3 1980 UNICEF Mid-Decade Conference

The objective of the United Nations Children's Fund (UNICEF) is two-fold. First, it provides assistance to governments (primarily in developing countries) to improve their national nutritional programs and child health and welfare services. Second, it provides direct aid in the form of food and medical supplies to children in emergency situations. UNICEF works in conjunction with the WHO in order to approach the issue of female genital mutilation from a health-care perspective, with the intention of instigating action at the community level in all affected countries (Dorkenoo et al., 1992: 18).

In July 1980, at the Mid-Decade Conference for Women, UNICEF issued a special Press Release (#IN/80/8 - 7 July 1980) on "Female Excision: UNICEF's Position", in which the recommendations of the Khartoum Seminar are cited.

4.1.4 1981 UN Sub-Commission Session

During the 1981 session of the UN Sub-Commission for the *Prevention of Discrimination and the Protection of Minorities*, the Minority Rights Group, a human rights organization based in London, England, presented a comprehensive report about FGM (Brennan, 1989: 372). The Sub-Commission members were confronted with the question that is central to this conflict: what behavior constitutes a cultural practice? Moreover, should the human rights bodies decline to consider practices, such as female circumcision, that are legitimate expressions of cultural values but which appear to conflict with international human rights norms (Brennan, 1989: 378)? Most of the conduct examined by the UN is not culturally based. Many of the practices that attract the attention of human rights advocates are abuses by government officials of the rights of their citizens. An important function of the UN, therefore, is to provide a forum to which victims of human rights abuses can take their complaints about their own governments (Brennan, 1989: 374).

A 1982 resolution resulting from this session called for a study of "all aspects of the problem of female genital mutilation, including the current extent and causes of the problem and how it might best be remedied" (Brennan, 1989: 380). This study was approved by the UN parent bodies of the Sub-Commission and was expanded to include several traditional practices harmful to the health of women and children.

Subsequently, the UN Commission on Human Rights, during its 1988 session, adopted a resolution asking the Sub-Commission to investigate national and international measures for eradicating traditional practices harmful to women and children. Ultimately, the Sub-Commission adopted a resolution that declared that FGM is a violation of Human Rights. However, rather than imposing its views on cultures that do not agree with them, the human rights bodies declared that they would serve a "consciousness-raising" function (Brennan, 1989: 395).

4.1.5 United Nations Convention on the Rights of the Child

The Convention on the Rights of the Child was adopted by the General Assembly of the United Nations on November 20, 1989. A number of the articles of the convention apply to FGM:

- Article 24, item 3 states that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".
- Article 19 reads: "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child".
- Article 16 states that "no child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation".
- Article 37, paragraph (a) reads, in part: "States Parties shall ensure that: No child shall be subjected to torture, or other cruel, inhuman, or degrading treatment or punishment..."

4.1.6 1991 United Nations Human Rights Seminar on 'Traditional Practices'

The first UN Human Rights seminar addressing 'traditional practices' was held in Ouagadougou, Burkina Faso, in May 1991. The purpose of the seminar was to suggest different forms of legislation, education, and other measures to eradicate all forms of harmful traditional practices (including FGM). In addition, the likelihood that such practices, if made illegal, would occur in a clandestine manner was also a dominant issue.

4.1.7 May 1994, Forty-Seventh World Health Assembly

At the forty-seventh World Health Assembly, a resolution entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children" was adopted. Female genital mutilation was referred to throughout the document. One part of the preamble reads:

> Recognizing that, although some traditional practices may be beneficial or harmless, others, particularily those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks or rickets and anemia;

Articles 1 to 3, which form the main body of the resolution read:

> 1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governents in countries where female genital mutilation is practiced;
>
> 2. URGES all Member States:
>
> > 1. to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;
> >
> > 2. to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;
> >
> > 3. to collaborate with national non-governmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;
>
> 3. REQUESTS the Director-General

1. to strengthen WHO's technical support to and cooperation with Member States in implimenting the measure specified above;

2. to continue global and regional collaboration with the networks of nongovermental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and traditional practices;

3. to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

4.1.8 9th UN Congress on the Prevention of Crime and the Treatment of Offenders

The 9th UN Congress on the Prevention of Crime and the Treatment of Offenders was held in Cairo (Egypt) on April 29 - May 8, 1995. The congress adopted two resolutions referring to the issue of FGM.

The resolution concerning "Children as victims and perpetrators of crime and the United Nations criminal justice programme: from standard setting towards implimentation and action" urges States, in order to eliminate violence against children, to adopt, in the absence of existing laws, initiatives, including measures to prohibit traditional practices prejudicial to the health of children, including female genital mutilation.

The second resolution relating to the "Elimination of violence against women" which was initially introduced by Canada with the contribution of Turkey, also "urges Member States, in order to eliminate all forms of violence against women, to adopt, in the absence of existing laws, initiatives including measures to prevent, prohibit, eliminate and impose effective sanctions against... all practices harmful to women and girl children, including female genital mutilation".

4.2 Other International Groups Working to Eradicate FGM

4.2.1 The Working Group on Traditional Practices Affecting the Health of Women and Children

Formed in Geneva in 1977, the Working Group is composed of NGO's associated with the Economic and Social Council of the United Nations (ECOSOC), the Special Committee on Human Rights, and its Sub-Committee on the Condition of

Women. The Group's primary focus is training medical and social workers working in affected rural populations, to document rituals involving excision, educating people with regard to its medical consequences, and develop effective ways to eradicate the procedure (Hedley & Dorkenoo, 1992: 20).

4.2.2 1992 London Declaration

From July 6 - 8, 1992, the Foundation for Women's Health Research and Development (FORWARD) held the First Study Conference on Genital Mutilation of Girls in Europe, in London England. Participants at this Conference included the World Health Organization, the United Nations, Minority Rights Group International, among other organizations, as well as representatives from France, Germany, Italy, the Netherlands, Sweden, the United Kingdom, Canada, USA, and the Gambia.

5.0 ATTEMPTS TO ERADICATE FEMALE GENITAL MUTILATION IN COUNTRIES OTHER THAN CANADA

The view that the practice of mutilating the genitalia of girls and women is unethical and/or unnecessary has been advanced by numerous feminist, medical, government and non-government organizations throughout the world. In some countries, these views have been acted upon at the levels of public education, medical awareness, and through the implementation of laws that specifically prohibit FGM -- e.g., the *Prohibition of Female Circumcision Act*, UK, 1985).

5.1 Australia

During 1993 and 1994, the Family Law Council of Australia reviewed the practice of female genital mutilation and recommended a specific prohibition on the practice as well as a provision similar to section 273.3 of Canada's *Criminal Code*. That section of the *Code*, which came into force August 1, 1993, prohibits a person from, among other things, doing anything for the purpose of removing a girl who is ordinarily resident of Canada from the country with the intention of performing FGM on her.

Furthermore, an education program to be integrated with Australia's health advancement and child value and protection agendas was proposed. It was suggested that it is essential that affected communities be involved with planning, as well as delivering, education programs.

5.2 Egypt

A resolution was signed by Egypt's Minister of Health in 1959, recommending only partial clitoridectomy for those who consent to the practice, to be performed solely by a medical doctor (Dorkenoo & Elworthy, 1992: 11). All other forms of female genital mutilation were prohibited until 1995 when Egypt decided to medicalize them in an attempt to render the practices safer. It was believed that by having such procedures performed in a hospital under more sanitary conditions it would eventually reduce some of the detrimental physical and psychological risks associated with FGM.

5.3 France

At present, France does not have specific legislation on FGM. Nonetheless, in November 1991 the French Commission for Appeals of Refugees became the first judicial authority to recognize female 'circumcision' as a form of persecution under the terms of the 1951 United Nations Convention Relating to the Status of Refugees. This

landmark ruling has now set a precedent for the determination of claims by fugitives from female 'circumcision' in other countries that have a similar refugee determination process (Oosterveld, 1993: 278)[7]. Furthermore, under *Articles 222-9* and *222-10* of the new *Penal Code* that came into force the first day of March, 1994, FGM is considered a criminal offence. In 1994, despite public pressure for a harsher sentence, a traditional exciser received a suspended one-year sentence for performing excisions on one month old baby girls (Gumble, The Ottawa Citizen, 17/9/94).

5.4 Kenya

After 14 separate reports of the deaths of female children as a result of excision, the Kenyan government prohibited the practice of female genital mutilation. As a result, any individual caught performing any act of FGM can be arrested and tried under the Kenya *Chief's Act* (Dorkenoo & Elworthy, 1992: 11).

5.5 New Zealand

In the *Criminal Amendment Act (No. 2) 1994*, there is a section dealing with female genital mutilation that came into force January 1, 1996. The relevant provisions amend the *Crimes Act 1961* by creating two new sections. New section 204A expressly prohibits female genital mutilation, while making exceptions for proper medical procedures performed for the benefit of a woman's health. New section 204B contains two offences. One offence will make it unlawful to aid, incite, counsel or procure the genital mutilation, outside of New Zealand, of any New Zealand citizen or person ordinarily resident in New Zealand. The other offence will make it unlawful to incite, counsel, procure, or induce any New Zealand citizen or resident to submit, outside New Zealand, to genital mutilation.

5.6 Norway

In 1985, all hospitals in Norway were alerted to the different forms of female genital mutilation, however, it is not yet considered an illegal act (Dorkenoo & Elworthy, 1992: 11).

5.7 Somalia

Somalia established a commission to eradicate infibulation in 1978 with the assistance of the Somali Women's Democratic Organization (SWDO). In 1988 at a seminar held in Mogadishu, it was proposed that the SWDO should draft a bill to

[7] For more information see RE Aminatta Diop, French Commission for Appeals of Refugees, recours No. 164,078.

eradicate all forms of female genital mutilation. At present, there is no indication in the literature as to whether this bill was actually passed.

5.8 The Sudan

Although certain forms of female genital mutilation have been outlawed since 1946, it is estimated that 80 percent of Sudanese girls and women continue to be mutilated. (Dorkenoo & Elworthy, 1992: 28). Anyone arrested for performing an excision or infibulation ritual is subject to a prison term not exceeding five years and/or a fine. However, under *Article 284* of the *Sudan Penal Code* any form of genital mutilation involving just the removal of the projecting part of the clitoris is not an offense.

5.9 Sweden

Sweden was the first Western country to introduce a law prohibiting female excision, regardless of consent (July 1982). The legislation involves a two-year prison sentence for guilty parties (Minority Rights Group, 1992/93: 11).

5.10 United Kingdom

Britain has legislation, the *Prohibition of Female Circumcision Act 1985*, that specifically makes the practice of FGM an offence.

Prior to 1985, any legal action taken against an individual as a result of the performance of female genital mutilation required proof of malicious intent to wound or cause grievous bodily harm. However, in most instances the performance of FGM on a child by parents is motivated by cultural and/or religious expectations, as well as love and concern for their children. Accordingly, the 1985 amendment was believed to be necessary because of the difficulty in proving malicious intent in such cases. This *Act* makes it punishable by fine or imprisonment for any person to excise, infibulate, or otherwise mutilate the whole or any part of the labia majora, labia minora, or clitoris of another person and/or aid, abet, counsel, or procure another person to perform such acts (Hayter, 1984: 323).

The *Act* is very clear as to what should not be performed, however, some obstetricians are faced with the dilemma of how to repair the vulva after the infibulation has been disrupted during labor/delivery. The *Act* states that it is not unlawful for either a registered medical practitioner or midwife to perform a surgical operation on the vulva on a woman during any stage of labor or shortly after giving birth, solely for reasons connected with that labor or birth (Jordan, 1994: 95).

The Foundation for Women's Health, Research and Development (FORWARD), based in London England, has been pushing for the eradication of FGM since the early 1980s and has published several training manuals for grassroots organizations. *Female Circumcision and Consciousness Raising: A Manual for Educators and Group Facilitators* (ND) and *Female Genital Mutilation: A Counseling Guide for Professionals* (ND) were created to aid to counselors dealing with the emotional aspects of FGM. Other FORWARD publications include: *Child Protection and Female Genital Mutilation* (ND), *Another Form of Abuse* (ND), *Report on First National Conference on Female Genital Mutilation* (ND), and *Female Genital Mutilation* (ND).

The Minority Rights Group (MRG) is an international research and information organization also based in London, England. Through investigations and the publication of information, the Group's principal objective is to provide access to justice for groups suffering discrimination, as well as to educate and raise public awareness throughout the world. Minority Rights Group publications on FGM include: *Female Genital Mutilation: Proposals for Change* (1992), *Female Circumcision, and Excision, and Infibulation* (ND).

5.11 United States

In late 1994, Minnesota prohibited the practice of circumcision, excision, or infibulation of females. Consent by the minor or the minor's parents is not considered a defense. However, a "surgical procedure" is exempted if it is necessary for the health of a girl/woman and if it is performed by a licensed physician. The effective date of implementation was delayed for one year to allow for adequate notice to be given to affected communities. The legislation also includes an education and outreach component, with supporting financial resources.

In New York State, legislation entitled *New York State Prohibition of Female Genital Mutilation Act* was proposed in 1994 and again on January 12, 1995 into the New York State Assembly and Senate. The *Act* is similar to the Minnesota bill in that it prohibits all forms of female genital mutilation and includes an exception for surgical procedures. It also makes the parents/legal custodians of a child who allow the procedure to be performed criminally liable. The penalty is still being debated.

Legislation entitled the *Federal Prohibition of Female Genital Mutilation Act of 1993* is currently before the House of Representatives. The bill, H.R. 3247, was introduced by Democratic representatives Patricia Shroeder of Colorado, and Barbara-Rose Collins of Michigan. Under *the International Covenant on Civil and Political Rights*, it includes an amendment pertaining to FGM in title 18 of the *United States Code*. The amendment states that any mutilation of the genitalia of a female under the age of 18 (excluding necessary surgical procedures) will result in a fine and/or imprisonment not exceeding 5 years. In addition, a proposal for a three-level program

of prevention, education and outreach to immigrant communities where girls might be at risk is outlined.

At present, there is no data indicating the prevalence of the practice of FGM in the United States.

6.0 CANADIAN TREATMENT OF FGM

There is no evidence that FGM is being practised in Canada. Nonetheless, there is considerable interest in the issue by members of concerned communities, non-governmental organizations, and by health and legal professionals. As a result, the issue of FGM is currently being addressed in the literature, through public education, in the areas of law, health, and socio-cultural implications by the federal and provincial/territorial governments, non-government organizations, and the media.

6.1 The Federal Government

6.1.1 *Criminal Code*

On December 14, 1995, Bill C-119 was tabled in the House of Commons. It proposed to amend the *Criminal Code* to clarify that the practice of FGM constituted aggravated assault within the meaning of section 268. Although the Bill died on the Order Paper when the House prorogued on February 2, 1996, the Minister of Justice indicated an interest in re-introducing a new bill to the same effect.

6.1.2 Federal Interdepartmental Working Group on Female Genital Mutilation

Chaired by Health Canada, with representatives from the Department of Justice, Canadian Heritage, Citizenship and Immigration Canada, Status of Women Canada, and Human Resources Development Canada, this Federal Working Group is currently examining the development of public and professional educational materials on the practice of FGM in Canada. This commitment to address the issue of FGM is consistent with international instruments to which Canada is a signatory.

The Federal Interdepartmental Working Group has sponsored consultations in Ottawa and Montreal with members of communities whose countries of origin retain female genital mutilation as a traditional practice. The results of these consultations appear in the report, *Female Genital Mutilation: Report on Consultations held in Ottawa and Montreal* (Hussein & Shermarke, 1995). The purpose of the consultations was to outline the most appropriate way in which to educate members of communities regarding the implementation of Canadian law, health risks, and socio-cultural/religious issues surrounding FGM and to provide the Federal Working Group with recommendations regarding sensitive and effective measures that can be undertaken by the federal government to ensure that FGM is not practiced in Canada, and that girls are not removed from Canada in order to be mutilated. A detailed list of recommendations is provided.

The Federal Interdepartmental Working Group has also provided support to the Ontario FGM Prevention Task Force and Women's Health in Women's Hands.

6.1.3 Immigration and Refugee Board

In March 1993, Canada became the first country in the world to introduce refugee board guidelines permitting women to claim refugee status on the basis of gender persecution.

On May 10, 1994, Canada granted refugee status to a Somali woman, her 10 year old daughter, and her seven year old son based upon the woman's belief that her daughter would be subjected to FGM if the family were forced to return to Somalia (Fennell, 1994).

In July 1995, the Federal Court of Canada upheld the appeal of a Ghanian woman, Faustina Annan, who was denied refugee status despite the threat of genital mutilation if she returned to her country. The judge said that commisioners from the Immigration and Refugee Board erred when they denied Annan refugee status, and ordered the Board to hold a second hearing with two new commissioners.

6.2 Provincial/Territorial Governments

Each province and territory has a statute providing for the protection of children; for example, Ontario's *Child and Family Services Act*, Quebec's *Youth Protection Act*, and British Columbia's *Child, Family and Community Services Act*. However, there have been no reported cases of child protection proceedings initiated as a result of the performance of FGM on a girl.

6.2.1 Ontario FGM Prevention Task Force

The Ontario FGM Prevention Task Force, chaired by the Ontario Women's Directorate, was established in February 1994 by the then Minister Responsible for Women's Issues, Marion Boyd. The goal of the Task Force was to develop strategies and recommendations for education and prevention concerning the legal, medical, community and social implications of female genital mutilation.

The Task Force was comprised of representatives from concerned communities, provincial/municipal agencies and the Ontario and federal government. The work of the Task Force included holding consultations and the development of various memoranda to corrections and legal professionals. The memoranda included: (1) a memo to all Ontario Chiefs of Police and Commissioners of the Ontario Provincial Police detailing the modes of investigation and charging with respect to FGM (Oct. 7, 1994); and (2) a memo to Crown Attorneys outlining the guidelines for charges and prosecution of FGM (Oct. 12, 1994).

6.2.2 Forum on Refugee Women (Vancouver)

Human Rights activist Margaret Akulia, with sponsorship from the Public Participation Program of the Canadian International Development Agency (CIDA) through the British Columbia Council for International Cooperation (BCCIC), held the Forum on Refugee Women on July 15, 1995. The forum included a section entitled "Female Genital Mutilation: Somali Community Perspectives".

6.3 Non-Governmental Organizations

6.3.1 Provincial/National Medical Associations

Most provincial Medical Associations have issued policy statements officially condemning FGM. The first medical association to put forth a position statement regarding FGM was the Council of the College of Physicians and Surgeons of Saskatchewan. Their position as of December 1991 was that they "do not condone the practice of female circumcision as it is a procedure which has very considerable potential for both physical and psychological harm to those who are subjected to it".

Following the advancement of this position, five other medical associations followed suit in support of that opinion. The available opinions include: The College of Physicians and Surgeons of Ontario (1/92); The College of Physicians and Surgeons of Manitoba (2/92); The Society of Obstetricians and Gynecologists of Canada (2/92); The College of Physicians and Surgeons of British Columbia (3/92); The College of Physicians and Surgeons of Alberta (9/94); and the Canadian Medical Association (2/95).

6.3.2 City of Toronto Department of Public Health

The City of Toronto, Department of Public Health, in association with the Somali Women's Support Group and the Canadian Center for Victims of Torture, have developed a series of information pamphlets entitled *Female Genital Mutilation (Circumcision), Are You Circumcised? Let's Talk About It*, and *The Pap Test*[8]. The pamphlets are intended as educational tools for Somali immigrants living in Toronto, covering the issues of myths surrounding FGM, circumcision and marriage, medical problems, gynecological information, and FGM and Canadian law.

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[8] These pamphlets are distributed to the public in Somali -- *Gudniinka Dumarka, Haddad Gudantahay: "Aan Ka Sheekeysanno"* and *Baaridda Ilma Galeenka Afkiisa*. The English translations are intended for the use of health educators only.

6.3.3 Women's Health in Women's Hands

The Toronto-based Women's Health in Women's Hands Community Health Center in Conjunction with the Toronto Department of Public Health has produced a series of three unilingual brochures (in Somali) which outlines why FGM is not considered an acceptable practice in Canada. These brochures have also been duplicated in English in order to assist service providers in addressing this issue.

Two pamphlets entitled *Female Genital Mutilation: Information for Educators and Service Providers to Support the Student and her Family* and *Female Genital Mutilation: Pre and Post Natal Care of the Patient* have also been developed for the purposes of education and consciousness-raising. The brochures and pamphlets are distributed via workshops and mail order requests. They describe the procedures involved in FGM and state that FGM is illegal in Canada.

At present, a further pamphlet is being prepared to assist physicians in dealing with cases of female genital mutilation.

Women's Health in Women's Hands hosted a workshop on FGM at the Canadian Council for Refugees in Ottawa, June 1994. The workshop resulted in the passing of a resolution, with six recommendations:

1. The United Nations should recognize FGM as a human rights issue, and that the procedure should be treated as a violation of those rights.
2. Request that the *Criminal Code* of Canada be amended to specifically identify FGM as a criminal act, and explore the possibility of appropriate new legislation.
3. Urge the Federal and Provincial Ministries to appropriate funds and resources to provide counseling and support groups for victims of FGM, for educational programs to take place within the communities in which FGM is traditionally practiced, and to raise awareness in non-affected cultures in Canada, health services providers and educational institutions.
4. Continue to pursue the issue of FGM through information sharing, education and advocacy.
5. Explore the inclusion of FGM on the platform for action in the fourth world conference on women, in Beijing 1995.
6. Urge Canada to provide protection to women and their daughters who are fleeing the FGM practice.

6.3.4 Family Violence, Law and Health Workshop (Vancouver)

Vancouver's People's Law School and the Immigrant and Visible Minority Women of BC held a Family Violence, Law and Health workshop on November 17, 1994. The workshop, organized by the People's Law School staff member Katayoun

Shirzed, took place after consultation with several immigrant women from countries were FGM remains a customary procedure. A representative from the BC Ministry of Attorney General spoke at this event.

6.3.5 Horn of Africa

In 1993, a team of professionals from the Horn of Africa Resource and Research Group worked under a grant from the Women's Health Bureau of the Ontario Ministry of Health to develop a workshop entitled "Educating Health Professionals on Female Genital Mutilation". The purpose of the project was three-fold: (1) to educate health professionals on the health risks associated with these practices; (2) to address the issue of child protection in suspected cases of FGM; and (3) to provide community education on the topic.

A basic premise of the project was that only women who had personal experience within a culture that condoned this traditional practice could speak to the issue authentically. Other women with a sense of togetherness with women's suffering would act as facilitators and supporters.

6.3.6 Computer Assisted Research

In an attempt to learn of other organizations addressing the issue of female genital mutilation in Canada, queries were made through two computerized information databases; the Access to Justice Network (ACJ-Net) and Minority Advocacy Rights Council Database (M.A.R.C.), and the Internet.

6.3.6.1 The Access to Justice Network (ACJ-Net)

Searches done via the ACJ-Net queried Public Legal Education and Information (PLEI) organization members with three questions regarding the issue of FGM:

1. Is your organization developing or delivering programs regarding FGM?

2. Are you aware of any other organizations that have, or are developing, programs or other initiatives regarding FGM with a Public Legal Education and Information component?

3. Do you think that PLEI would play a useful role in addressing the issue of female genital mutilation?

The query netted only twelve responses; ten negative and two positive. The ten negative respondents replied that their organizations were not addressing the issue of FGM and that they knew of no other organizations that were. The two positive respondents agreed that Public Legal Education and Information has a useful role to play regarding FGM. Some of their recommendations include:

- Partnerships between immigrant serving organizations to educate their clientele on Canada's position regarding FGM.
- PLEI should focus on developing and implementing programs on FGM in Canadian regions where the practice is believed to be present.
- PLEI should take a broader cross-cultural approach as opposed to specific legal information. This would be done to better address the issues of cultural sensitivity and cultural determinism.
- The formulation of closed-training workshops for community workers who are, or might be, dealing with FGM.
- Organize public awareness campaigns via the media with the intent of eliminating the cultural barriers and taboos surrounding this practice.

6.3.6.2 The Minority Advocacy Rights Council Database (M.A.R.C.)

The M.A.R.C. database is designed to be searched using subject key words. Using the key words 'female', 'genital', 'mutilation', and 'circumcision', no hits were recorded. As a result of this search, one can conclude that FGM is not yet identified as a justice issue of concern to ethnocultural groups who are members of the M.A.R.C. database.

6.3.6.3 The Internet

An initial search of the Internet was conducted using key word searches in the World Wide Web. Using the key words 'female genital mutilation', 'FGM', 'female circumcision', 'circumcision', 'excision', 'sunna', 'introcision', and 'infibulation', no hits were recorded.

A search of the Use-Net discussion groups was also conducted using the same key word identifiers. This search revealed a copy of the United States draft legislation *H.R. 3247*, various descriptive text files, three medical photographs (JPeg format), and one of an autoerotic self-infibulation (a woman

sewing her labia minora shut with needle and thread -- JPeg format)[9], however no other information was available at the time of this search[10].

6.4 The Canadian Media

The amount of coverage given to the topic of female genital mutilation by the Canadian media has varied over the past decade, increasing considerably since 1991. Although not representative of all Canadian media reports on FGM, this section provides an overview of the range of recent coverage dedicated to this issue.

6.4.1 Print Media

The topic of female genital mutilation has appeared in The Ottawa Citizen, The Ottawa Sun, The Globe & Mail, The Toronto Star, The Toronto Sun, L'Express, La Presse, The Montreal Gazette, Le Devoir, Le Soleil, The Lethbridge Herald, and The Hamilton Spectator, Macleans, Ms., and Homemakers Magazine.

The first observed Canadian print coverage of FGM occurred in 1983 when the Globe and Mail published an article entitled *Female Circumcision Necessary, say African Women in Canada* (Roberge, April 22 1983), which related the beliefs and attitudes of several immigrant women towards FGM as an integral symbol of their cultural identity.

There have been four periods of escalation in coverage of the topic of FGM: (1) in 1991 when the College of Physicians and Surgeons of Ontario prepared to release its policy statement regarding FGM; (2) in March 1994 with the release of recommendations by the Canadian Advisory Council on the Status of Women calling on all levels of government and health/legal professionals to take action against FGM and with the subsequent formal response (written and verbal) by the Minister of Justice to these recommendations; (3) in July 1994 when Canada granted Khadra Hassan Farah and her children refugee status after they fled the ritual practice in their native Somalia; and (4) during the United Nations Population Conference in Cairo in September. Other topics discussed in the media include general information on FGM, Canadian medical and legal positions with respect to the procedure, speculation surrounding the continuation of the practice in North America and Europe, violence against women, FGM and AIDS, and Canada's role in challenging gender-related prosecution. A

[9] Self infibulation is considered a form of atypical autoerotic activity. Such activities involve a wide variety of potentially dangerous practices including bondage, infibulation and genital mutilation with objects and/or electricity, and life-threatening games (see Lanning, 1982, Ferguson, 1995).

[10] It is important to note that information can pass through Internet newsgroups at an extremely fast rate. Most of the information that was downloaded in these initial searches had disappeared from the newsgroups in which it was found in under 48 hours. Therefore, it is possible that subsequent searches of the Internet would reveal more information.

recent article that appeared in The Montreal Gazette examined Egypt's decision to legalize all forms of FGM with the intent of making the practice safer (Galwash, June 2, 1995).

6.4.2 Radio

The CBC news broadcast "Sunday Morning" addressed the topic of female genital mutilation in a 'limits of mulitculturalism' production on February 14, 1993. The reporter, Beth Gaines, interviewed high school students and teachers, physicians, and members of the Somali-Canadian Association in Etobicoke for their opinions regarding FGM procedures, as well as their views on the extent to which such procedures may be occurring in Canada.

Similarly, the Toronto talk-radio station CFRB aired two one-hour interactive news programs with respect to FGM on September 28 and 29, 1994. Both CFRB broadcasts were comparable in content to the CBC broadcast.

6.4.3 Television

In April 1995, the weekly CBC Newsworld documentary "Rough Cuts" aired an episode entitled "Our Daughter's Pain: Female Genital Mutilation". The one-hour program examines the work of a number of women's and interest groups in Toronto and Ottawa addressing the issue of FGM. The program included graphic video footage of an infibulation ritual performed on a young Ethiopian girl.

6.4.4 Film[1]

Female genital mutilation is addressed briefly in the National Film Board (NFB)'s documentary *The Vienna Tribunal* (1994). Although not entirely dedicated to genital mutilation, the film does offer an FGM profile among the personal stories of abused women from around the world who testified before a panel of judges at the Global Tribunal on Violations of Women's Human Rights. The tribunal allowed women to challenge the worlds' leaders at the UN World Conference on Human Rights in Vienna to address the numerous forms of abuse endured by women world-wide (including FGM), and to recognize them as violations of universal human rights.

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[1] Other non-Canadian films dedicated to the topic of female genital mutilation include the BBC documentaries "Female Circumcision" (1983) and "A Cruel Ritual" (nd) produced by Louise Panthon, the World Health Organization sponsored "You Will Not Excise my Daughter" (nd), Soraya Mire's "Fire Eyes" (1994), and Alice Walker and Pratibha Parmar's "Warrior Marks" (1994).

7.0 SUMMARY

At present, the majority of the literature on female genital mutilation focuses on the negative aspects of these procedures. Recent literature condeming the practice of FGM offers numerous medical, legal, human rights, historical, and religious arguments against the practice. This literature review has examined these issues with particular reference to positions held by international organizations such as the UN and the WHO, as well as those advanced by feminist, medical, governmental and non-governmental organizations in Canada, the United States, Britain, Western Europe, and Australia. In addition, relevant concepts and definitions were presented both to eliminate misconceptions surrounding FGM, and for use in future work addressing this issue.

The majority of the research reviewed here adopts the predominantly Western perspective that female genital mutilation is a violation of human rights, and stresses the procedure's numerous short and long-term physical and psychological consequences. Moreover, the practice of FGM is currently addressed in the context of male domination over women and children, religious misinterpretation (primarily of the Qu'ran (or Koran)), and as a non-justifiable medical procedure. The medical problems most often observed include gynecological and obstetrical complications, transmission of infectious disease including HIV, and scarification. As a result, female genital mutilation has been medically and legally prohibited in most Western nations, although Britain and Sweden are the only Western countries with legislation that expressly makes the practice of FGM an offence. The African nations of the Sudan, Kenya and Burkina Faso also have specific laws prohibiting FGM.

Fewer studies focus on the pressures faced by members of many immigrant populations who continue to view FGM as a positive and acceptable practice. A lack of understanding of the views of these cultures may impede the effectiveness of organizations attempting to implement viable proposals for change. Moreover, there is a lack of literature offering comprehensive examinations of the diverse nature of the societies where FGM rituals are still performed.

This literature review has examined the issue of female genital mutilation from many different perspectives. Such a multi-dimensional analysis of this issue promotes responsive and effective legislative and preventative action within both affected and non-affected cultures. Subsequently, such a comprehensive examination of the literature allows for a re-thinking of ways to approach FGM at the level of education, in order to eliminate the construction of public misconceptions surrounding the nature of the practice.

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